

Hearing Aid Repair Drop-Off Form

NAME: _____

LAST 4 SSN: _____

HEARING AID PROBLEM:

DEAD/WEAK

NEED NEW TUBE

AID DAMAGED

OTHER (PLEASE DESCRIBE BELOW)

STATIC/NOISY

INTERMITTENT

- ❖ IF YOU ARE SEEKING TO HAVE YOUR HEARING AID SETTINGS ADJUSTED THEN PLEASE SCHEDULE A FOLLOW-UP APPOINTMENT WITH YOUR AUDIOLOGIST

HOW WOULD YOU LIKE YOUR REPAIRED HEARING AID RETURNED TO YOU?

BY MAIL

CALL TO PICK -UP
